STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDDIG	00	COMPL	ETED
		155330		LDING		01/28/	2013
			B. WIN		ADDRESS SITY STATE TIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R		1	ADDRESS, CITY, STATE, ZIP CODE		
0.41.514.6	22000110				NNIE AVE		
SALEM	CROSSING			SALEM	l, IN 47167		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
			F00	000	Please find the enclosed plan	of	
	This visit was for a Recertification and				correction for survey ending		
	State Licensur				January 28, 2013. Submission	n of	
	Otate Election	c sarvey.			this plan of correction does no	ot	
	Cm. / a al = 4	January 22, 22, 24			constitute admission or		
	Survey dates: January 22, 23, 24,				agreement by the provider of		
	25, and 28, 20	13			truth of facts alleged or correct	tion	
					set forth on the statement of		
	Facility numbe	r: 000223			deficiencies. This plan of correction is prepared and		
	Provider numb	er: 155330			submitted because of		
	AIM number:	100267680			requirement under state and		
					federal law. Please accept thi	is	
	Survoy toom:				plan of correction as our credi		
	Survey team:	N TO			allegation of compliance. Due		
	Diana Sidell R				the low scope and severity of		
	Gloria Reisert,				survey finding, please find		
	Jill Ross RN (J	January 22, 23, 24, and			sufficient documentation		
	25, 2013)				providing evidence of complia		
					with the plan of correction. Th		
	Census bed ty	pe:			documentation serves to confi	ırm	
	SNF/NF: 90	•			the facility's allegation of compliance. Thus, the facility		
	Total: 90				respectfully requests the gran	tina	
	10101. 00				of paper compliance, feel free		
	Conque nover	tuno:			contact me with any questions		
	Census payor						
		9					
	Medicaid: 6						
	Other: 1	6					
	Total: 9	0					
	These deficien	icies also reflect state					
		n accordance with 410					
	IAC 16.2.	45501441100 Willi 710					
	170 10.2.						
							ı

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000223

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A DUIL DDIG	00	COMPLETED		
		155330	A. BUILDING	3. WING 01/28/2013			
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE			
			200 CONNIE AVE				
SALEM C	ROSSING		SALEM	l, IN 47167			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE		
F0272	483.20(b)(1)	,					
SS=D		VE ASSESSMENTS					
00-D		conduct initially and					
	•	nprehensive, accurate,					
		oducible assessment of					
	each resident's fu						
	A facility must ma	ake a comprehensive					
		resident's needs, using the					
		ent instrument (RAI)					
	specified by the S	State. The assessment					
	must include at le	east the following:					
	Identification and	demographic information;					
	Customary routing						
	Cognitive patterns	s;					
	Communication;						
	Vision;						
	Mood and behavi						
	Psychosocial well						
	Physical functioni	ng and structural					
	problems;						
	Continence;						
	•	s and health conditions;					
	Dental and nutrition	onal status;					
	Skin conditions;						
	Activity pursuit;						
	Medications;	ts and procedures;					
	Discharge potenti						
	• .	f summary information					
		litional assessment					
		care areas triggered by					
	•	the Minimum Data Set					
	(MDS); and	and annually bala dot					
	Documentation of	f participation in					
	assessment.	, ,					
		rd review, interview	F0272	1. Resident#20 had a 3-day	02/01/2013		
		n the facility failed to	- 0 - 1 -	voiding diary and bladder	02,01,2013		
		•		assessment completed. IDT			
	do a complete			conducted a bladder continend	ce		
	assessment of			review. 2. All residents have th			
	resident. This	affected 1 of 3		potential to be affected. Bladde	-		
				<u> </u>			

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Event ID: VZ8Q11

Facility ID: 000223

If continuation sheet Page 2 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH DDIG	00	COMPLETED	
		155330	A. BUILDING		01/28/2013	
			B. WING	ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP CODE		
				ONNIE AVE		
SALEM	CROSSING		SALEN	л, IN 47167		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	residents reviewed for assessments.			assessments were completed	on	
(Resident #20)			all residents. Toileting progra	ms		
	(110010011111120)			and care plans were updated		
	Findings includ	la.		accordingly. 3. Continence		
	Findings include	ie:		assessment to be conducted		
				quarterly and upon a significa		
	Record review	for Resident #20 was		change on all residents by the	;	
	done on 1/23/1	3 at 2:00 p.m.		DNS or designee. IDT will	iou	
	Diagnoses incl	uded, but were not		conduct bladder continent rev to ensure a toileting program		
	•	A (stroke) with right		place if appropriate and will	3 111	
		, ,		develop a plan of care if		
	sided paralysis, high blood pressure, depression, expressive aphasia			appropriate. All nursing staff		
	•	•		in-serviced by SDC on the		
		and congestive heart		following by 2-1-13: Bladder		
	failure.			Program Policy and Procedure	e	
				(See Attachment A), Bladder		
	There was no	assessment done to		Continence (See Attachment	В),	
	show how ofte	n the resident required		Restorative Nursing Programs	3	
	to be toileted to	•		Policy and Procedure (See		
		o ao nopi ary.		Attachment C), FIT Toileting		
	An interview w	ith Resident #20's		Program (See Attachment D),		
				Scheduled Toileting Evaluatio (See Attachment E), Instruction		
	_	done on 1/23/13 at		for Completion of ADL Record		
		e indicated she put her		Policy and Procedure (See	•	
	mother's call li	ght on at 11:30 a.m., so		Attachment F), Documentation	n	
	they could take	e her mother to the		Guidelines for Nursing (See		
	bathroom. At	11:55 a.m., staff came		Attachment G), and Care Plar	1	
	to take residen	t to the bathroom.		Review and Maintenance		
		clean clothes as the		Process Policy and Procedure		
	_	een incontinent. The		(See Attachment H). 4. DNS of		
				designee will complete a Blad	der	
	_	ated her mother has a		Program Audit Tool (See		
		and went to the		Attachment H) 5 days a week		
		y hour when she was		times 4 weeks for all new		
	home. She inc	dicated they have told		admissions/readmissions and residents with an Assessment		
	staff since the	resident came into the		Reference Date, then up to 10		
	facility but they	will not toilet her as		residents weekly times 4 week		
	she needs to b			then every other week times 4		
				weeks, then monthly times 3		
	1		1		1	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	00 	COMPLETED
	155330	B. WING		01/28/2013
SALEM (PROVIDER OR SUPPLIER	200 CC SALEM	ADDRESS, CITY, STATE, ZIP CODE DNNIE AVE 1, IN 47167	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	An interview with the MDS Coordinator was done on 1/25/13 at 2:50 p.m. She indicated the CNA's are not required to chart what happened each time they check a resident. "They only have to mark if the resident was continent or incontinent on their shift." A policy titled, "Bladder Program" was received from the Director of Nursing on 1/28/13 at 10:37 a.m. This policy indicated, "3. The resident should be checked and offered toileting every hour during waking hours" 3.1-31(a)	TAG	months, then quarterly for at I 6 months. The audits will be reviewed during the facility's 0 meetings and issues will be addressed and the above plat be altered accordingly if the threshold is not 95% or above	east CQI n will

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Event ID: VZ8Q11

Facility ID: 000223

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155330	A. BUIL B. WING			01/28/	2013
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	t			NNIE AVE		
SALEMO	CROSSING				, IN 47167		
	ANOSSING			SALLIVI	, 110 47 107		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL			ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0279	483.20(d), 483.20(k)(1)						
SS=D	DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the						
		e the results of the evelop, review and revise					
		nprehensive plan of care.					
	the resident's con	inprenentiave plant of care.					
	The facility must develop a comprehensive care plan for each resident that includes						
	measurable object	ctives and timetables to					
		medical, nursing, and					
		nosocial needs that are					
	identified in the co	omprehensive assessment.					
	The care plan may	est alonguillo the governo					
		ust describe the services nished to attain or maintain					
		hest practicable physical,					
		hosocial well-being as					
		483.25; and any services					
		vise be required under					
		not provided due to the					
	resident's exercis	se of rights under §483.10,					
	including the righ	t to refuse treatment under					
	§483.10(b)(4).						
	Based on record re	eview, interview and	F02	79	1. Resident #20 had a 3-day		02/01/2013
	observation the fac	cility failed to implement a			voiding diary and bladder		
		Id meet the needs of the			assessment completed. IDT		
	•	ected 1 of 23 residents			conducted a bladder continend		
					review. Care plan developed t		
	reviewed for care	plans. (Resident #20)			address resident incontinence.		
					CNA assignment sheet update based on care plan. 2. All	;u	
	Findings include:				residents have the potential to	he	
					affected. Bladder assessments		
	Record review for	Resident #20 was done on			were completed on all resident		
	1/23/13 at 2:00 n n	n. Diagnoses included, but			Toileting programs and care		
	•	: CVA (stroke) with right			plans were updated according	ly.	
		, ,			3. IDT will conduct bladder		
	sided paralysis, high blood pressure,				continent review to ensure a ca		
		ssive aphasia (cannot			plan is developed quarterly and		
	speak) and conges	stive heart failure.			upon a significant change for a		
					residents as appropriate. MDS	>	

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Event ID: VZ8Q11

Facility ID: 000223

 ${\rm If\ continuation\ sheet}\qquad \hbox{Page\ 5\ of\ 20}$

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			COMPLETED	
		155330	A. BUILDING B. WING 01/28/2013				
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			NNIE AVE		
SALEMO	CROSSING				, IN 47167		
					, 114 47 107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	E	PLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	•		ATE
	· ·	n initial date of 7/8/10,			coordinator will ensure care plare developed within 3 days of		
	indicated to assist	resident with toileting and			IDT review. All nursing staff		
	peri care after eac	h incontinent episode.			in-serviced by SDC on the		
	"Toilet Q 2 (every	2 hours) and PRN (as			following by 2-1-13: Bladder		
	needed) while awa	ake."			Program Policy and Procedure	:	
	,				(See Attachment A), Bladder		
	An interview with F	Resident #20's daughter			Continence (See Attachment E	3),	
		/13 at 11:45 a.m. She			Restorative Nursing Programs Policy and Procedure (See		
		ner mother's call light on at			Attachment C), FIT Toileting		
		y could take her mother to			Program (See Attachment D),		
		-			Scheduled Toileting Evaluation	n	
		11:55 a.m., staff came to			(See Attachment E), Instructio	ns	
		e bathroom. They also took			for Completion of ADL Record		
		ne resident had been			Policy and Procedure (See		
		laughter indicated her			Attachment F), Documentation Guidelines for Nursing (See		
	mother has a wea	k bladder and went to the			Attachment G), and Care Plan		
	bathroom every ho	our when she was home.			Review and Maintenance		
	She indicated they	have told staff since the			Process Policy and Procedure		
	resident came into	the facility but they will not			(See Attachment H). 4. DNS o	r	
	toilet her as she no	eeds to be.			designee will complete a Care Plan Review Audit Tool (See		
					Attachment J) 5 days a week		
	An interview with t	he MDS Coordinator was			times 4 weeks for all new		
		t 2:50 p.m. She indicated			admissions/readmissions and		
		required to chart what			residents with an Assessment		
		ne they check a resident.			Reference Date, then up to 10		
		mark if the resident was			residents weekly times 4 week then every other week times 4	s,	
		tinent on their shift."			weeks, then monthly times 3		
		unent on their stillt.			months, then quarterly for at le	ast	
		adder Dreament was			6 months. The audits will be		
		adder Program" was			reviewed during the facility's C	QI	
		Director of Nursing on			meetings and issues will be	sadil	
		.m. This policy indicated,			addressed and the above plan be altered accordingly if the	WIII	
		should be checked and			threshold is not 95% or above		
	_	ery hour during waking					
	hours"						

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Event ID: VZ8Q11

Facility ID: 000223

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155330		(X2) MULTIPLE CO	00 	COM	PLETED 28/2013				
		100000	B. WING	ADDRESS OFFI OF THE STA	_	.0/2010			
SALEM (PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 CONNIE AVE SALEM, IN 47167						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE			
	3.1-35(a) 3.1-35(b)(1)								

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Event ID: VZ8Q11

Facility ID: 000223

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DBIG	00	COMPL	ETED
		155330	A. BUII			01/28/2013	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.					
CALEMA	ROSSING				NNIE AVE		
SALEIVIC	RUSSING			SALEIVI	l, IN 47167		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0310	483.25(a)(1)						
SS=D	ADLS DO NOT D	ECLINE UNLESS					
	UNAVOIDABLE						
		nprehensive assessment of					
		cility must ensure that a					
		s in activities of daily living					
		nless circumstances of the					
		al condition demonstrate					
		as unavoidable. This					
		lent's ability to bathe, dress,					
		fer and ambulate; toilet;					
	•	ech, language, or other					
		unication systems.					
	Based on recoi	rd review, interview	F03	10	1. Resident #20 had a 3-day		02/01/2013
	and observatio	n the facility failed to			voiding diary and bladder		
	ensure the resi	dent was toileted			assessment completed. IDT		
	according to he	er needs for a resident			conducted a bladder continend	ce	
	_	dependent on staff.			review. Toileting is		
	,	•			accommodating to her needs.	4:-1	
	This affected 1				All residents have the potento be affected. Bladder	แลเ	
		DL decline. (Resident				on	
	#20)				assessments were completed all residents. Toileting prograr		
					and care plans were updated	113	
	Findings includ	le:			accordingly. CNA assignment		
					sheets updated. Residents		
	Dogard ravian	for Resident #20 was			toileted per bladder assessme	nts	
					and care plans. 3. DNS or	-=	
	done on 1/23/1	•			designee will conduct rounds		
	•	uded, but were not			every day on all shifts to ensur	е	
	limited to: CVA	A (stroke) with right			residents are toileted per the 0		
	sided paralysis	, high blood pressure,			assignment sheets. All nursing		
	•	pressive aphasia			staff in-serviced by SDC on the		
	•	and congestive heart			following by 2-1-13: Bladder		
	,	and congestive near			Program Policy and Procedure	•	
	failure.				(See Attachment A), Bladder		
					Continence (See Attachment B	•	
	There was no a	assessment done to			Restorative Nursing Programs		
	show how ofter	n the resident required			Policy and Procedure (See		
	to be toileted to	·			Attachment C), FIT Toileting		
	to bo tonotod to	so hope ary.			Program (See Attachment D),	_	
					Scheduled Toileting Evaluation	I	

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Event ID: VZ8Q11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJI	LDDIG	00	COMPL	ETED
		155330		LDING		01/28/	2013
			B. WIN		PDDEGG CVTV GTATE JID GODE		-
NAME OF P	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
0415446	ND O O O IN IO				NNIE AVE		
SALEM CROSSING				SALEM	, IN 47167		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	During a walk	down the hall on			(See Attachment E), Instructio	ns	
	1/22/13 at 2:45	5 p.m., Resident #20's			for Completion of ADL Record		
		bserved to be wet, and			Policy and Procedure (See		
	_	iddle on the floor under			Attachment F), Documentation	1	
	her wheelchair				Guidelines for Nursing (See		
	i i ci wi icciciiali	•			Attachment G), and Care Plan Review and Maintenance		
		:			Process Policy and Procedure		
		ith Resident #20's			(See Attachment H). 4. DNS o		
	_	done on 1/23/13 at			designee will complete a Blade		
	11:45 a.m. Sh	e indicated she put her			Program Audit Tool (See		
	mother's call li	ght on at 11:30 a.m., so			Attachment I) 5 days a week		
	they could take	e her mother to the			times 4 weeks for all new		
	bathroom. At	11:55 a.m., staff came			admissions/readmissions and		
		it to the bathroom.			residents with an Assessment		
		clean clothes as the			Reference Date, then up to 10 residents weekly times 4 week		
	-	een incontinent. The			then every other week times 4		
					weeks, then monthly times 3		
	_	ated her mother has a			months, then quarterly for at le	east	
		and went to the			6 months. The audits will be		
		y hour when she was			reviewed during the facility's C	:QI	
	home. She inc	dicated they have told			meetings and issues will be		
	staff since the	resident came into the			addressed and the above plan	will	
	facility but they	will not toilet her as			be altered accordingly if the		
	she needs to b				threshold is not 95% or above		
	On 1/25/13 at	11·41 a m					
		are was provided for					
		•					
		Her clothes were wet.					
		ted they do not have to					
		e resident was dry or					
	did not urinate	. When the					
	documentation	was pulled to show					
	her urine outpu	ut there was nothing					
	•	though the resident					
	was wet at the	_					
	incontinence c						
		a. o.					

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Event ID: VZ8Q11

Facility ID: 000223

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		155330	B. WIN			01/28/2013
NAME OF B	DROVIDED OD GUDDU IED		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			200 CO	NNIE AVE	
SALEM (CROSSING			SALEM	, IN 47167	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA:	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		ith Resident #20's				
		one on 1/25/13 at 12:00				
	p.m. He indica	•				
	_	on yesterday (1/24/13)				
		A CNA came into the				
		the light off and said				
		ight back. At 12:00				
	l ·	ed her up to the				
	shower room s	o they could toilet her.				
	He had to ask	staff to take care of				
	her. All her clo	thing was now wet.				
	An interview w	ith CNA #2 was done				
	on 1/25/13 at 1	0:00 a.m. She				
	indicated this re	esident was more				
	incontinent tha	n continent.				
	The MDS date	d 1/7/13 indicated				
	resident was n	ot on a toileting				
		s always incontinent				
	1	f continent voiding)".				
		σ,				
	An interview w	ith the MDS				
	Coordinator wa	as done on 1/25/13 at				
	2:50 p.m. She	indicated they are not				
		a toileting program				
		e on paper. They may				
		t every 2 hours but if it				
		n paper it is not				
		pileting program. She				
		the CNA's are not				
		irt what happened each				
		k a resident. "They				
		ark if the resident was				
	i continent or inc	continent on their shift."				

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Event ID: VZ8Q11

Facility ID: 000223

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	of Correction identification number: 155330	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP	LETED B/2013			
	PROVIDER OR SUPPLIER CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 200 CONNIE AVE SALEM, IN 47167						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE			
	A policy titled, "Bladder Program" was received from the Director of Nursing on 1/28/13 at 10:37 a.m. This policy indicated, "3. The resident should be checked and offered toileting every hour during waking hours" 3.1-38(a)(2)							

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Event ID: VZ8Q11

Facility ID: 000223

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	UILDING 00			COMPLETED	
		155330	B. WIN			01/28/	2013	
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER							
CALEMA	CDOCCINIC				NNIE AVE , IN 47167			
SALEIVIC	CROSSING			SALEIVI	, IN 47 107			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0312 SS=D	RESIDENTS A resident who is activities of daily I necessary service nutrition, groomin hygiene. Based on record and observationensure a reside on staff was to needed to keep	unable to carry out living receives the es to maintain good g, and personal and oral and review, interview and the facility failed to ent totally dependent leted as often as to the resident dry. This aresidents reviewed for	F03	12	Resident #20 had a 3-day voiding diary and bladder assessment completed. IDT conducted a bladder continent review. Toileting is accommodating to her needs. All residents have the poten		02/01/2013	
(of daily living) decline.			to be affected. Bladder assessments were completed all residents. Toileting prograr and care plans were updated accordingly. CNA assignment sheets updated. Residents toileted per bladder assessment.	on ns		
	done on 1/23/1 Diagnoses including the CVA sided paralysis depression, exp	for Resident #20 was 3 at 2:00 p.m. uded, but were not A (stroke) with right , high blood pressure, pressive aphasia and congestive heart			and care plans. 3. DNS or designee will conduct rounds every day on all shifts to ensur residents are toileted per the Cassignment sheets. All nursing staff in-serviced by SDC on the following by 2-1-13: Bladder Program Policy and Procedure (See Attachment A), Bladder Continence (See Attachment E Restorative Nursing Programs	CNA e - s		
	show how ofter to be toileted to During a walk of 1/22/13 at 2:45	dessessment done to the resident required to be kept dry. I down the hall on the p.m., Resident #20's poserved to be wet and			Policy and Procedure (See Attachment C), FIT Toileting Program (See Attachment D), Scheduled Toileting Evaluation (See Attachment E), Instruction for Completion of ADL Record Policy and Procedure (See Attachment F), Documentation Guidelines for Nursing (See	ns		

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Facility ID: 000223

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155330	B. WING			01/28/	2013
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	R			NNIE AVE		
SALEM CROSSING					, IN 47167		
SALEW CROSSING				SALLIVI	, 111 47 107		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	there was a pu	ddle on the floor under			Attachment G), and Care Plan		
	her wheelchair.				Review and Maintenance		
					Process Policy and Procedure		
	An interview w	ith Resident #20's			(See Attachment H). 4. DNS o		
		done on 1/23/13 at			designee will complete a Blado Program Audit Tool (See	ı c ı	
	_				Attachment I) 5 days a week		
		e indicated she put her			times 4 weeks for all new		
		ght on at 11:30 a.m., so			admissions/readmissions and		
		her mother to the			residents with an Assessment		
		11:55 a.m., staff came			Reference Date, then up to 10		
		t to the bathroom.			residents weekly times 4 week		
	They also took	clean clothes as the			then every other week times 4		
	resident had be	een incontinent. The			weeks, then monthly times 3	4	
	daughter indica	ated her mother has a			months, then quarterly for at le 6 months. The audits will be	east	
	weak bladder a				reviewed during the facility's C	·OI	
		y hour when she was			meetings and issues will be	Q1	
		-			addressed and the above plan	will	
		dicated they have told			be altered accordingly if the		
		resident came into the			threshold is not 95% or above.		
		will not toilet her as					
	she needs to b	e.					
	On 1/25/13 at	11:41 a.m.,					
		are was provided for					
		Her clothes were wet.					
		ted they do not have to					
		•					
		e resident was dry or					
	did not urinate.						
		was pulled to show					
	her urine outpu	ut there was nothing					
	recorded even	though the resident					
	was wet at the time of the incontinence care.						
	An interview w	ith Resident #20's					
	· •	one on 1/25/13 at 12:00					
	p.m. He indica	nted he put the					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155330	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 28/2013		
	PROVIDER OR SUPPLIEF	.	STREET ADDRESS, CITY, STATE, ZIP CODE 200 CONNIE AVE SALEM, IN 47167					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
	at 11:35 a.m. room and shut she would be r p.m., he wheel shower room she had to ask her. All her closs the had to ask her. An interview where the had to a to ask her. A policy titled, and the had to ask her. A policy titled, and the had to ask her. A policy titled, and the had to ask her. A policy titled, and the had to ask her. A policy titled, and the had to ask her. A policy titled, and the had to ask her. A policy titled, and the had to ask her. A policy titled, and the had to ask her. A policy titled, and the had to ask her. All her closs	d 1/7/13 indicated ot on a toileting s always incontinent f continent voiding)".						

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155330	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY IPLETED 28/2013		
	PROVIDER OR SUPPLIEF	·	STREET ADDRESS, CITY, STATE, ZIP CODE 200 CONNIE AVE SALEM, IN 47167					
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
	indicated, "3. be checked an	0:37 a.m. This policy The resident should d offered toileting ing waking hours"						
	3.1-38(a)(3)(A))(B)(C)(D)(E)						

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Facility ID: 000223

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155330		A. BUIL	DING	00	(X3) DATE S COMPL 01/28 /	ETED	
		100000	B. WING		ADDRESS, CITY, STATE, ZIP CODE	01/20/	2010
NAME OF P	ROVIDER OR SUPPLIER				NNIE AVE		
SALEM C	CROSSING				, IN 47167		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
				IAG	,		DATE
F0431 SS=D	& BIOLOGICALS The facility must eservices of a licer establishes a systand disposition of sufficient detail to reconciliation; and records are in ordall controlled drug periodically reconding must be labeled in accepted professinclude the approcautionary instructed when applicationary instructed when applicationary instructed when applicationary in the facility must sufficient in lock proper temperature authorized person keys. The facility must permanently affixed storage of control schedule II of the Abuse Prevention and other drugs storages.	employ or obtain the nsed pharmacist who tem of records of receipt fall controlled drugs in enable an accurate d determines that drug ler and that an account of gs is maintained and ciled. Icals used in the facility in accordance with currently innal principles, and priate accessory and citions, and the expiration able.					
	drug distribution s quantity stored is	systems in which the minimal and a missing					
	record review,	rvation, interview, and the facility failed to tions were labeled in	F04:	31	Resident #22 and Resident #55 medications were labeled appropriately. 2. All residents have the potential to be affected. Nursing Managemen	t	02/01/2013

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STATEMENT OF DEFICIENCIES X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDEN		IDENTIFICATION NUMBER:	A DIJII DING	00	COMPLETED	
		155330	A. BUILDING B. WING		01/28/2013	
			_	ET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	R		CONNIE AVE		
SALEM CROSSING				EM, IN 47167		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROP		
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	accordance wi	th accepted standards		completed a 100% audit on		
	of practice, for	2 of 3 medications		medications in the medication		
	carts and 2 of	90 residents.		3. IDT will explain to all new		
	(Resident #22	and #55)		admitted residents and their		
				families the protocol for havi		
	Findings include	de:		labels on Over the Counter		
				Medications that are brough		
	During a medi	cation cart observation,		thefacility from outside phar	macy	
	_	9:18 a.m., with LPN #3,		sources during the Road to	and	
	·	cart for the 300 hall		Recovery/Cottage meetings also discussed during care p		
		to have the following:		meetings. All nursing staff	Jan	
		•		in-serviced by SDC by 2-1-1	3 on	
		uate allergy and sinus		Pharmakon Labeling of		
		d Resident #22's name		Medication Policy and Proce		
		bottle with a marker,		(See Attachment K). 4. DN	S or	
		no label with the		designee will complete a Medication Rooms and Cart		
	required inforn			Audit (See Attachment L) or		
		contained 1 bottle		medication carts 3 times a w		
	each of 'Omep	razole' (reduces		times 2 weeks, then 2 times		
	stomach acid)	with Resident #55's		week times 2 weeks, then o	nce a	
	name written o	on the boxes and		week times a month, then of		
	contained no la	abel with the required		month times 3 months, then		
	information.			quarterly for at least 6 month		
	- 1 bottle of 'Ty	/lenol' 325 milligrams,		The audits will be reviewed the facility's CQI meetings a	•	
		#55's name written with		issues will be addressed and		
		nad no label with the		above plan will be altered		
	required inforn			accordingly if the threshold i	s not	
	•	nin C, 500 milligrams,		95% or above.		
		# 55's name written				
		and had no label with				
	the required in					
		adine, 10 milligrams (for				
		had Resident #55's				
ı		on with a marker, and				
		abel with the required				
	information.					

STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDDIG	00	COMPLETED	
		155330	A. BUI. B. WIN	LDING		01/28/	/2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R					
CALEMO	CDOSSINO		200 CONNIE AVE SALEM, IN 47167				
SALEM CROSSING				SALEIVI	, 111 47 107		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	- 1 bottle 'col-ri	ite' stool softener, 100					
	milligrams, witl	h resident #55's name					
	written with a r	narker, and no label					
		ed information.					
	-	acid with no name or					
	label.	acia marrio name ei					
	label.						
	During a modi	cation cart observation,					
		•					
	•	2:51 p.m., with LPN #4,					
		cart on the 400 hall					
		to have the following:					
	- 3 bottles of 8	1 milligrams aspirin					
	with no label a	nd no resident name					
	- 1 bottle of vita	amin D3 with no label					
	and no resider	nt name					
	- 1 bottle of 'Or	ne A Day' vitamins with					
		o resident name					
		reservision' with no					
	label and no re						
		ed PE' pressure and					
	· ·	bel and no resident's					
	name						
	During an inter	view on 1/25/13 at					
	2:55 p.m., LPN	I #4 indicated the					
	family brought	in the medications.					
	A policy and p	rocedure for "Labeling					
	A policy and procedure for "Labeling of Medication" was provided by the						
	Director of Health Services on 1/28/13 at 12:37 a.m. The policy						
	-	vas not limited to,					
	· ·	ensure all prescriptions					
	are labeled in a	accordance with state					
and federal regulationsProcedure:							

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	1		
		155330	B. WIN	G		01/28/	2013	
NAME OF F	PROVIDER OR SUPPLIER	_		STREET A	ADDRESS, CITY, STATE, ZIP CODE			
			200 CONNIE AVE					
SALEM (CROSSING			SALEM	, IN 47167			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	6.01 All Medica							
	·	er: Labeling for all						
		ust be: Typed or						
	printed and cle							
	Resident/patier							
		mber, Name and						
	_	drug, Route and						
	time(s) the med	dication is to be given						
	(if indicated on	the prescription order),						
	Quantity of dru	g/medication						
	dispensed, Dat	e dispensed,						
	Expiration date	of all time dated						
	drugs, Prescrib	er's name, The name,						
	address, and to	elephone number of						
	the dispensing	pharmacy, Any other						
	pertinent inforn	nation as may be						
	needed or requ	ıiredAll						
	non-prescriptio	n (OTC) medications						
	or vitamin supp	plements supplied by						
	[Pharmacy] wil	bear a prescription						
	label which will	contain all information						
	as specified in	6.01 in this manual.						
	All non-prescrip							
		vitamin supplements						
		resident or residents						
		ar a prescription label						
		ain all information as						
		ction 6.01 in this						
	l .	TC medications must						
		by a physician and						
	-	ephone order or						
	admission orde							
	prescription"	•						
	F. 555bilo							
	3.1-25(j)							
	5.1 25()							

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	OF CORRECTION	IDENTIFICATION NUMBER: 155330	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPI 01/28	LETED			
	NAME OF PROVIDER OR SUPPLIER SALEM CROSSING			STREET ADDRESS, CITY, STATE, ZIP CODE 200 CONNIE AVE SALEM, IN 47167					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE			
	REGULATORY OF			(EACH CORRECTIVE ACTION	N SHOULD BE				

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